Report to the Legislature

Community Options Program

Community Options Program Waiver

Calendar Year 2004

Department of Health and Family Services
Division of Disability and Elder Services
Bureau of Long Term Support

Executive Summary

The Community Options Program (COP) began with the passage of the 1981 state budget. The purpose of the program was to create a home and community-based alternative to nursing home care. Wisconsin had a high use of nursing homes, with significant annual increases in nursing home spending. The Community Options Program was intended to offer more choices for older people and people with disabilities at a lower cost to the state. In 1986, Wisconsin received a federal Medicaid Home and Community-Based Waiver for people who are elderly or have a physical disability, which allowed the state to get federal matching funds for COP with some flexibility in how it would meet the Title 19 (Medicaid) requirements. The Community Options Program serves a limited number of people and is not an entitlement.

The state-funded Community Options Program – Regular serves people who are elderly or who have a physical, developmental or mental disability. The COP Medicaid waiver serves only people who are elderly or have a physical disability. This includes the Community Options Program-Waiver (COP-W) and the Community Integration Program II (CIP II). Different waivers serve people with developmental disabilities.

In 2004, COP and all home and community-based waiver programs served a total of 26,923 people, of which 9,322 or 35 percent were elderly, 12,204 or 46 percent were persons with developmental disabilities, 4,436 or 16 percent were persons with physical disabilities, 852 or 3 percent were persons with mental illness, and 9 were persons with alcohol and/or drug abuse (AODA).

In 2004, $58 million of state COP served five client populations. In addition, $143 million of state and federal funding was spent on elders and people with physical disabilities under the COP Waiver and CIP II programs. Long term care waivers for children and those with developmental disabilities spent $325 million.

Individuals who use waiver services are also eligible for the Medicaid fee-for-service ("card") benefits, and must use the Medicaid card before relying on the waivers to fill gaps in care. Participants in CIP II and COP-W used $131,816,864 in benefits from their Medicaid card. The largest expenditures were for prescription drugs ($50 million) and personal care ($36 million).

The *average* daily cost of care for participants in CIP II and COP-W in Calendar Year (CY) 2004 was $89.07. This includes state and federal funds totaling $284.2 million per year. The *average* daily cost of care for people in nursing homes, at the same combination of levels of care, was $108.01 of Medicaid funds.

Almost three-fourths of COP and all waiver participants received care in their own homes or apartments; only 14 percent were living in community-based residential facilities (CBRF). A majority of the participants also had family or friends involved in providing voluntary care. Quality assurance reviews measured high rates of consumer satisfaction, especially for people living in their own homes.

Table of Contents

LIST OF FIGURES AND TABLES

Table of Contents (cont.)

INTRODUCTION

This report is submitted pursuant to s. 46.27(11g) and s. 46.277(5m), of the Wisconsin Statutes, which requires summary reporting on state funds appropriated in the biennial budget process for the Community Options Program. The Community Options Program (also known as COP-Regular or Classic COP) serves all client groups in need of long-term care and is entirely state-funded.

The statutes also permit COP funds to be used with the flexibility to expand Medicaid waiver programs. The federal government grants waivers of Medicaid rules to permit states to provide long-term care at home to a population that qualifies for Medicaid coverage of nursing home care. State funds are matched by federal Medicaid dollars at a ratio of about 40:60. The Community Options Program-Waiver (COP-W) is limited to persons who are elderly and/or persons with a physical disability. The federal Community Options Program-Waiver also includes the Community Integration Program II (CIP II). (See Appendix B.)

Other Medicaid waiver programs are targeted to specific populations in need of long-term care services. Community Integration Program 1A (CIP 1A), and Community Integration Program 1B (CIP 1B) serve the community needs for long-term care participants with developmental disabilities. Brain Injury Waiver (BIW) serves individuals who have received brain injury rehabilitation. The Community Options Program state funding is often used as match for federal funds through these waivers. Children's Long Term Support Waivers (CLTS) serves persons under the age of 22 who have a developmental disability, physical disability and those who have a severe emotional disturbance.

This report describes the persons served, program expenditures and services delivered primarily through COP, COP-W and CIP II in CY 2004. Information on all waivers has been reported where data was available. Medicaid waiver funding combined with Medicaid card funded services (acute care) and COP provides a comprehensive health care package to recipients. It is critical that these programs be closely coordinated in order to ensure that the most comprehensive and individualized care is provided. With this kind of coordination, Wisconsin residents are provided with a safe, consumer-controlled alternative to life in an institution. As this report demonstrates, these programs also help contain the costs of providing long-term care to a fragile population.

STRUCTURE

The Department of Health and Family Services administers COP and COP-W while the programs are managed by county agencies. Funds are allocated to counties based on the Community Aids formula (base allocation) or for special needs, such as nursing home relocations or to address waiting lists. The success of the Community Options Program is measured both by how well the program is able to help contain the use and cost of Medicaid-funded nursing home care, and by producing positive outcomes for the program participants. Both COP and COP-W together provide complementary funding to enable the arrangement of comprehensive services for people in their own homes based on the values of consumer direction and preference. The local Community Options Program Plan describes local resource coordination of the county policies and practices, and assures the prudent, cost-effective operation of the program. Each county COP Plan is updated annually with approval by the local Long-Term Support Planning Committee. State level program management monitors local compliance with federal and state program requirements.

PARTICIPANTS SERVED BY PROGRAMS

The following table provides information about the numbers of participants in various waiver programs. The Community Options Program, in combination with Medicaid waiver funds, is used to support individuals in the community. The program category column in Table 1 lists each funding source by type of Medicaid waiver, and when each waiver is combined with COP funding. (See Appendix B for program definitions.) The categories of participants are elderly, persons with physical disabilities (PD), persons with developmental disabilities (DD), persons with severe mental illness (SMI), and persons with alcohol and/or drug abuse (AODA).

TABLE 1 - Participants Served by Programs During 2004 with COP and all Waivers

Program Category	Elderly	PD	DD	SMI	AODA	Medicaid Waiver Funds Only	Waiver w/Additional COP	Total Served Unduplicated
COP-W								8,969
Waiver Only	4,394	1,549				5,943		
Waiver/COP	2,430	596					3,026	
CIP II								3,625
Waiver Only	1,010	1,404				2,414		
Waiver/COP	672	539					1,211	
Sub Total COP-W/CIP II	8,506	4,088	0	0	0	8,357	4,237	12,594
CIP 1A	Elderly	PD	DD	SMI	AODA			1,225
Waiver Only	45		1,116			1,161		
Waiver/COP	4		60				64	
CIP 1B Regular								3,015
Waiver Only	198		2,706			2,904		
Waiver/COP	6		105				111	
CIP 1B COP Match								2,420
Waiver/COP for match only	95		2,086			2,181		
COP match waiver w/other COP	15		224				239	
CIP 1B Other Match								4,529
Waiver/other for match	175		4,265			4,440		
Waiver/COP	10		79				89	
Brain Injury Waiver								228
Waiver Only		140	67			207		
Waiver/COP		17	4				21	
Brain Injury COP Match								11
Waiver/COP for match only		6	2			8		
COP match waiver w/other COP		3	0				3	
Brain Injury Waiver Other Match								83
Waiver/other for match		43	36			79		
Waiver/COP		2	2				4	
Sub Total DD Waivers	548	211	10,752	0	0	10,980	531	11,511
CLTS	Elderly	PD	DD	SMI	AODA			1,358
Waiver Only		2	1,332	11		1,345		
Waiver/COP		0	13	0			13	
CLTS COP Match								14
Waiver/COP for match only		2	5	3		10		
COP match waiver w/other COP		4	0	0			4	
CLTS Other Match								147
Waiver/other for match		7	122	17		146		
Waiver/COP		0	1	0			1	
Sub Total CLTS Waivers	0	15	1,473	31	0	1,501	18	1,519
COP Only Participants	268	122	79	821	9			1,299
Totals by Target Population	9,322	4,436	12,304	852	9	20,838	4,786	TOTAL
% Served by Target Population	34.6%	16.5%	45.7%	3.2%	0.03%	77.4%	17.8%	26,923

NOTE: Participants with a dual diagnosis are counted under the funding program. Source: 2004 HSRS.

- Total unduplicated participants served in 2004 - 26,923.
- Total participants who were served by a Medicaid waiver only (no COP funds) - 20,838.
- Total Medicaid waiver participants who also received COP funding in CY 2004 - 4,786.
- Total participants who received only COP funding (not Medicaid eligible) - 1,299.
- All participants who received either pure COP or COP to supplement waiver funds - 6,085.
- Total participants served with COP and COP-W funds - 14,227.

PARTICIPANTS SERVED BY TARGET GROUP

The Community Options Program and all the home and community-based waivers combined served a total of 26,923 persons. The table below illustrates participants served in 2004 with COP and Medicaid waiver funding by target group.

TABLE 2
Participants Served by Target Group During 2004 with COP and All Waivers

Target Group	COP Only	COP-W	Subtotal COP Only, COP-W	All Other COP Used as Match	CIP II	Subtotal COP Only, COP-W, Other COP, CIP II	CIP 1, CLTS, BIW	GRAND TOTAL
Elderly	268 20.6%	6,824 76.1%	7,092 69.1%	130 4.7%	1,682 46.4%	8,904 53.5%	418 4.1%	9,322 34.6%
PD	122 9.4%	2,145 23.9%	2,267 22.1%	34 1.2%	1,943 53.6%	4,244 25.5%	192 1.9%	4,436 16.5%
DD	79 6.1%	0 0%	79 0.8%	2,581 93.9%	0 0%	2,660 16.0%	9,644 93.8%	12,304 45.7%
SMI	821 63.2%	0 0%	821 8.0%	3 0.1%	0 0%	824 5.0%	28 0.3%	852 3.2%
AODA	9 0.7%	0 0%	9 0.1%	0 0%	0 0%	9 0.1%	0 0%	9 0.03%
Total	1,299 4.8%	8,969 33.3%	10,268 38.1%	2,748 10%	3,625 13.5%	16,641 61.8%	10,282 38.2%	26,923 100.0%

Note: Totals may not equal 100% due to rounding. Source: 2004 HSRS.

- 9,322 or 35% were elderly;
- 4,436 or 16% were persons with physical disabilities (PD);
- 12,304 or 46% were persons with developmental disabilities (DD);
- 852 or 3% were persons with severe mental illness (SMI); and
- 9 or less than 1% were persons with alcohol and/or drug abuse (AODA).

FIGURE 1
Participants Served by Target Group During 2004 with COP and All Waivers

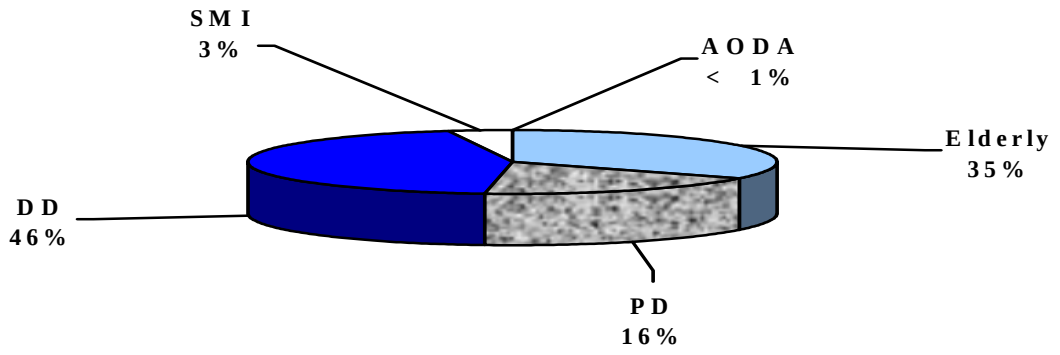


TABLE 3

Participants Served by Programs on December 31, 2004 (Point-In-Time) with COP and All Waivers

Program Category	Elderly	PD	DD	SMI	AODA	Medicaid Waiver Funds Only	Waiver w/Additional COP	Total Served Unduplicated
COP-W								7,233
Waiver Only	3,793	1,403				5,196		
Waiver/COP	1,601	436					2,037	
CIP II								3,069
Waiver Only	888	1,338				2,226		
Waiver/COP	461	382					843	
Sub Total COP-W/CIP II	6,743	3,559				7,422	2,880	10,302
CIP 1A	Elderly	PD	DD	SMI	AODA			1,188
Waiver Only	41		1,097			1,138		
Waiver/COP	3		47				50	
CIP 1B Regular								2,919
Waiver Only	191		2,648			2,839		
Waiver/COP	4		76				80	
CIP 1B COP Match								2,323
Waiver/COP for match only	92		2,038			2,130		
COP match waiver w/other COP	11		182				193	
CIP 1B Other Match								4,426
Waiver/other for match	163		4,206			4,369		
Waiver/COP	5		52				57	
Brain Injury Waiver								221
Waiver Only		135	69			204		
Waiver/COP		15	2				17	
Brain Injury COP Match								11
Waiver/COP for match only		7	2			9		
COP match waiver w/other COP		2	0				2	
Brain Injury Waiver Other Match								81
Waiver/other for match		43	35			78		
Waiver/COP		1	2				3	
Sub Total DD Waivers	510	203	10,456			10,767	402	11,169
CLTS	Elderly	PD	DD	SMI	AODA			1,292
Waiver Only		2	1,272	9		1,283		
Waiver/COP		0	9	0			9	
CLTS COP Match								14
Waiver/COP for match only		6	5	3		14		
COP match waiver w/other COP		0	0	0			0	
CLTS Other Match								144
Waiver/other for match		7	121	16		144		
Waiver/COP		0	0	0			0	
Sub Total CLTS Waivers	0	15	1,407	28	0	1,441	9	1,450
COP Only Participants	212	115	65	735	6			1,133
Totals by Target Population	7,465	3,892	11,928	763	6	19,630	3,291	24,054
% Served by Target Population	31.0%	16.2%	49.6%	3.2%	<0.01%	81.6%	13.7%	

NOTE: Participants with a dual diagnosis are counted under the funding program. Source: 2004 HSRS.

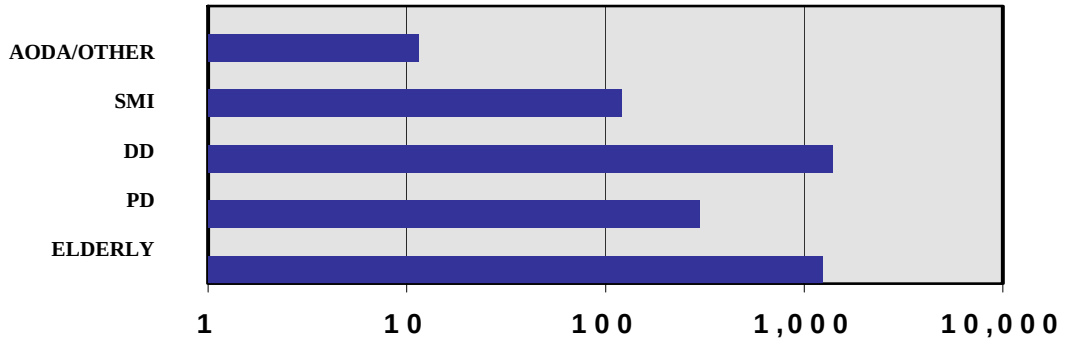
ASSESSMENTS, CARE PLANS AND PERSONS SERVED

The Community Options Program lead agencies provide eligible individuals with an assessment and care plan that identifies equipment, home modifications and services that might be available to assist them in their own homes and communities. During the assessment process, a social worker and other appropriate professionals assess each individual's unique characteristics, medical condition, living environment, lifestyle preferences and choices. The individual and the care manager develop a plan for a comprehensive package of services, which integrates and supports the informal and unpaid assistance available from family and friends. This care plan incorporates individual choices and preferences for the type and arrangement of services. Depending upon available income and assets, the individual may be responsible for paying some or all of the costs for services in their care plan. In 2004, 7,846 assessments were conducted, and 5,047 care plans were prepared.

NEW PERSONS

Figure 2 illustrates the target group distribution of the 4,639 new persons served during 2004. The majority of the new participants served in 2004 were persons with a developmental disability. Clients are considered new if they have services and costs in the current year and no long-term support services of any type in the prior year.

FIGURE 2
New Persons Receiving Services by Target Group in 2004
For COP and All Waivers



AODA/Other	SMI	DD	PD	Elderly
15 (.3%)	163 (3.5%)	2,219 (47.8%)	492 (10.6%)	1,750 (37.7%)

Source: 2004 HSRS.

PARTICIPANT CASE CLOSURES

Table 4 illustrates the number of participants in each target group who left the program in 2004 for various reasons. Approximately nine percent of all participants' cases were closed during 2004. About 47 percent of elderly case closures and 41 percent of closures of persons with physical disabilities were due to death. Approximately 32 percent of all cases that were closed were due to moving to an institution. Of the elderly cases closed, 41 percent were due to moving to an institution.

TABLE 4
Reasons for Participant Case Closures for COP and All Waivers

	Elderly	PD	DD	SMI	AODA	Other	Total
Person Died	800	175	91	16	1	4	1,087
Transferred to or Preferred Nursing Home Care	712	74	23	6	0	1	816
No Longer Income or Care Level Eligible	83	71	44	18	1	1	218
Moved	69	39	53	8	0	1	170
Voluntarily Ended Services	36	50	53	19	1	1	160
Other Funding Used for Services	10	10	16	19	2	0	57
Reside in ICF-MR/IMD Center	3	2	5	5	0	0	15
Medical Issues/Behavioral Challenges	2	5	0	2	0	0	9
Inadequate Service/Support	3	1	2	1	0	0	7
Transferred to Partnership Program	1	2	0	0	0	0	3
Other	1	1	0	0	0	0	2
Total Cases Closed (all reasons)	1,720	430	287	94	5	8	2,544

Source: 2004 HSRS.

PARTICIPANT TURNOVER RATE

The Community Options Program participants receive services as long as they remain eligible and continue to need services. In the past, two-thirds of COP and COP-W participants received services for three years or less. The other one-third of program participants are longer-term participants who received services for as long as ten years.

Turnover is defined as the number of new participants who need to be added in order to keep the caseload constant. For example, a local program may need to serve 125 persons during a year to maintain an average ongoing caseload of 100, and would have had a turnover of 25 participants. The turnover rate equals the amount of turnover divided by the total caseload. In this example, the turnover rate is 25 percent.

Table 5 illustrates the number of cases closed during 2004 divided by the caseload size on December 31, 2003 for each target group. The shaded row of Table 5 below shows the turnover rate for each target group. (The "other" category reflects reporting errors which are corrected by January 1, 2005.)

TABLE 5
Calculation of Turnover by Target Group for COP and All Waivers

	Elderly	PD	DD	SMI	AODA	Other	Total
All Persons Served During 2004	9,322	4,436	12,304	852	9	0	26,923
Point-in-Time Number of Persons Served on December 31, 2004	7,465	3,892	11,928	763	6	0	24,054
Number of Cases Closed During 2004 (Excludes Transfers to the Family Care Program)	1,720	430	287	94	5	8	2,544
Point-in-Time Number of Persons active on December 31, 2003 (Caseload Size)	7,451	4,013	10,144	747	7	1	22,363
Turnover Rate for the Above Case Closures	23%	11%	3%	13%	71%	n/a	11%

Source: 2004 HSRS.

NURSING HOME RELOCATIONS

In 2004, county long-term support agencies in 50 counties relocated 211 people from general nursing homes to community-based settings using funding from the COP-Waiver and CIP II programs. The Community Relocation Initiative, approved in the 2005-07 biennial budget and effective July 2005, expands the opportunity for relocations by enabling any eligible nursing home resident who wishes to relocate to do so. Next year's report on 2005 activity will reflect relocations from that initiative.

TABLE 6A
Number of Relocated Participants by Age Group

AGE GROUPS	18-34	35-54	55-64	65-74	75-89	90+	TOTAL
NUMBER OF PARTICIPANTS	5	29	29	21	103	24	211

Source: 2004 HSRS

TABLE 6B
COP-W/CIP II Relocated Participants by Type of Residence

TYPE OF RESIDENCE	Adult Family Home	CBRF	Own Home or Apartment	RCAC	Supervised Community Living	TOTAL
NUMBER OF PARTICIPANTS	16	70	119	4	2	211
PERCENTAGE	8%	33%	56%	2%	1%	100%

Source: 2004 HSRS

An additional six individuals were able to relocate with the assistance of one-time funding made available through a federal grant known as the Homecoming II project. This funding enabled individuals to set up their living arrangement; however, they were able to have their ongoing needs met by Medicaid or their own health insurance or income and did not need to rely on waiver funding.

COP FUNDING FOR EXCEPTIONAL NEEDS

Within the statewide Community Options Program a fund exists for exceptional needs. The Department may carry forward to the next fiscal year any COP and COP-W GPR funds allocated but not spent by December 31 (s. 46.27(7)(g), Wis. Stats.). These exceptional funds are made available to applicant counties for the improvement or expansion of long-term community support services for clients. Services may include:

a) start-up costs for developing needed services for eligible target groups;
b) home modifications for COP eligible participants and housing funding;
c) purchase of medical services and medical equipment or other specially adapted equipment; and
d) vehicle modifications.

In 2004, funds for exceptional needs were awarded to 37 counties. For example, individual awards include "homecoming" funds that allow people to purchase or pay for household furnishings, equipment, security deposits and other items to enable them to move from an institution into the community. Awards were made for home repairs and modifications such as ramps, mobility lifts, overhead track lifts, roll-in showers, raised toilets, lowered cabinets and fixtures, grab bars, wider hallways and doors, door openers, automatic controls for windows, lights, temperature devices, adapted beds, adapted chairs and other items. Awards were also made for adapted mobility equipment such as wheelchairs, walkers and scooters not covered by Medicaid, as well as van modifications.

SIGNIFICANT PROPORTIONS AND TARGET GROUPS SERVED WITH COP AND COP-W FUNDS

The **COP and COP-W funding** is intended to serve persons in need of long-term support at an institutional level of care. State statutes require that COP funding serve persons from the major target groups in proportions that approximate the percentages of Medicaid-eligible persons who are served in nursing homes or state institutions. These percentages are called "significant proportions."

The minimum percentages for significant proportions were initially set in 1984 and have been periodically adjusted to reflect changes in the growth of the long-term care population. The percentage for elderly has been set lower than the actual population to allow some county flexibility. The total minimum percentages add up to 84.2 percent with 15.8 percent reserved for county discretion.

TABLE 7A
Detail of 2004 Significant Proportions by Target Groups

2004

	Elderly	PD	DD	SMI	AODA	Other	Total
Total served excluding the Partnership Program and Milwaukee County Disability Services[1]	6,332	1,678	2,064	795	19	27	10,915
Percentage for above total	58.0%	15.4%	18.9%	7.3%	0.2%	0.2%	100%
Partnership Program participants served[2]	482	341	0	0	0	0	823
Total including the Partnership Program participants	6,814	2,019	2,064	795	19	27	11,738
Percentage for above total	58.1%	17.2%	17.6%	6.8%	0.2%	0.2%	100%
Participants served by Milwaukee County Disability Services[3]	10	584	815	114	0	0	1,523
Standard Methodology (including the above participants)[4]	6,824	2,603	2,879	909	19	27	13,261
Percentage for above total	51.5%	19.6%	21.7%	6.9%	0.1%	0.2%	100.0%

Source: 2004 HSRS, Reconciliation Schedules, and Partnership Enrollment Data.

TABLE 7B
Individuals and Percentages Used for Monitoring Significant Proportions 2001 - 2004

2001 – 2004

Year	Elderly	PD	DD	SMI	AODA	Other	Total
Minimum Percentages	57.0%	6.6%	14.0%	6.6%	0%		84.2%
2004[4]	6,824 51.5%	2,603 19.6%	2,879 21.7%	909 6.9%	19 0.1%	27 0.2%	13,261[4] 100%
2003[4]	7,003 49.6%	2,861 20.3%	3,327 23.6%	881 6.2%	23 0.2%	30 0.2%	14,125[4] 100%
2002[4]	6,738 48.8%	2,911 21.1%	3,338 24.2%	819 5.9%	8 0.1%	1 0.0%	13,815[4] 100%
2001	6,430 50.9%	2,035 16.1%	3,106 24.6%	967 7.7%	29 0.2%	68 0.5%	12,635 100%

Note: Counts reflect individuals served with COP and COP-W funding on December 31st of each year with adjustments applied.
Source: 2004 HSRS, Reconciliation Schedules, and Partnership Enrollment Data.

1. These numbers include calculation for COP funding used as overmatch and for county specific variances. They do not include individuals served by Milwaukee County Disability Services or those served by the Partnership Program who count for significant proportions.
2. Numbers of individuals served by the Partnership Program in Chippewa, Dane, Dunn, Eau Claire and Milwaukee County Disability Services who are counted for significant proportions.
3. Numbers of individuals served by Milwaukee County Disability Services with COP and COP-W funding.
4. Unduplicated count of individuals whose services are funded with COP Regular, COP-W or CIP IB when COP funding is used to provide the local match. The numbers include a calculation adjustment to factor in the amount of COP funding that is used as match for services above the CIP I and CIP II rate. (This methodology counts approximately one additional person for every $10,000 of COP regular funds used in this way.) Totals include adjustments for county specific variances and persons served by the Partnership Program and Milwaukee County Disability Services.

PARTICIPANT DEMOGRAPHIC AND SERVICE PROFILES

TABLE 8 - Census 2000 Wisconsin Population Compared to COP and All Waiver Participants by Race/Ethnic Background

RACE GROUPS/ ETHNIC BACKGROUND	Wisconsin Census 2000 Population by Race/Ethnic Groups		COP and All Waiver Participants By Race/Ethnic Groups	
	All Wisconsin Residents	Percent	COP and Waiver Participants	Percent
Caucasian	4,769,857	89%	24,549	91%
African American	304,460	6%	1,360	5%
American Indian/Native American	47,228	1%	316	1%
Asian	88,763	2%	349	1%
Other	153,367	3%	21	<1%
Hispanic	*n.a.	*n.a.	**328	**1%
TOTAL	5,363,675	100%	26,923	100%
*Hispanic/Latino (all races) 2000 Census	*192,921	*4%		

NOTE: *The U.S. Census considers "Hispanic/Latino" an ethnicity, not a race. "Hispanic/Latino" is reported in addition to race, and is not included in the race totals or percents in this table. **HSRS considers "Hispanic" a race; therefore, a comparison of the Census Hispanic Wisconsin residents and Hispanic COP & all waiver participants may not be consistent. Some totals may not equal 100% due to rounding. Source: 2000 Census, 2004 HSRS.

TABLE 9 - COP and All Waiver Participants by Race/Ethnic Background

PARTICIPANTS BY RACE/ETHNIC BACKGROUND	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Caucasian	8,766	3,518	11,225	966	74	24,549	91%
African American	178	504	585	92	1	1,360	5%
American Indian/Alaska Native	115	71	115	14	1	316	1%
Asian/Pacific Islander	178	45	118	5	3	349	1%
Unknown	11	1	9	0	0	21	<1%
Hispanic	76	71	174	7	0	328	1%
TOTAL	9,324	4,210	12,226	1,084	79	26,923	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2004 HSRS.

TABLE 10 - COP and All Waiver Participants who Relocated/Diverted from Institutions

RELOCATED/DIVERTED	Number	Percent
Diverted from Entering any Institution	23,199	86%
Relocated from General Nursing Home	1,563	6%
Relocated from ICF/MR	1,920	7%
Relocated from Brain Injury Rehab Unit	224	<1%
Other	17	<1%
TOTAL	26,923	100%

NOTE: Some totals may not equal 100% due to rounding. Source: 2004 HSRS.

TABLE 11 - COP and All Waiver Participants by Gender

PARTICIPANTS BY GENDER	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Female	6,968	2,357	5,153	563	39	15,080	56%
Male	2,356	1,853	7.073	521	40	11,843	44%
TOTAL	9,324	4,210	12,226	1,084	79	26,923	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2004 HSRS.

TABLE 12 - COP and All Waiver Participants by Age

PARTICIPANTS BY AGE	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Under 18 years	0	68	2,134	36	0	2,238	8%
18 – 64 years	0	4,142	10,092	1,048	79	15,361	57%
65 – 74 years	2,742	0	0	0	0	2,742	10%
75 – 84 years	3,564	0	0	0	0	3,564	13%
85 years and over	3,018	0	0	0	0	3,018	11%
TOTAL	9,324	4,210	12,226	1,084	79	26,923	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2004 HSRS.

TABLE 13 - COP and All Waiver Participants by Marital Status

PARTICIPANTS BY MARITAL STATUS	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Widow/Widower	4,430	193	42	19	8	4,692	17%
Never Married	1,450	1,696	11,809	744	21	15,720	58%
Married	1,917	929	152	52	17	3,067	11%
Divorced/Separated	1,387	1,312	180	249	29	3,157	12%
Other	140	80	43	20	4	287	1%
TOTAL	9,324	4,210	12,226	1,084	79	26,923	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2004 HSRS.

TABLE 14 - COP and All Waiver Participants by Natural Support Source

PARTICIPANTS BY NATURAL SUPPORT SOURCE	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Adult Child	4,592	611	25	52	19	5,299	20%
Non-Relative	1,110	806	2,134	248	9	4,307	16%
Spouse	1,475	826	90	33	16	2,440	9%
Parent	112	1,064	7,882	307	9	9,374	35%
Other Relative	1,348	548	1,276	137	14	3,323	12%
No Primary Support	687	355	812	307	12	2,173	8%
Other	0	0	7	0	0	7	<1%
TOTAL	9,324	4,210	12,226	1,084	79	26,923	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2004 HSRS.

TABLE 15 - COP and All Waiver Participants by Living Arrangement

PARTICIPANTS BY LIVING ARRANGEMENT	Elderly	PD	DD	SMI	AODA Other	Total Participants	
Living with Immediate Family	2,552	1,688	5,702	166	19	10,127	38%
Living Alone	3,537	1,113	682	375	21	5,728	21%
Living with Others with Attendant Care	1,563	444	3,004	282	22	5,315	20%
Living with Others	803	346	2,058	205	11	3,423	13%
Living Alone with Attendant Care	472	299	369	37	2	1,179	4%
Living with Immediate Family with Attendant Care	229	248	258	3	2	740	3%
Living with Extended Family	131	55	125	7	2	320	1%
Living with Extended Family with Attendant Care	25	10	15	1	0	51	<1%
Transient Housing Situation	4	5	3	6	0	18	<1%
Other	8	2	10	2	0	22	<1%
TOTAL	9,324	4,210	12,226	1,084	79	26,923	100%

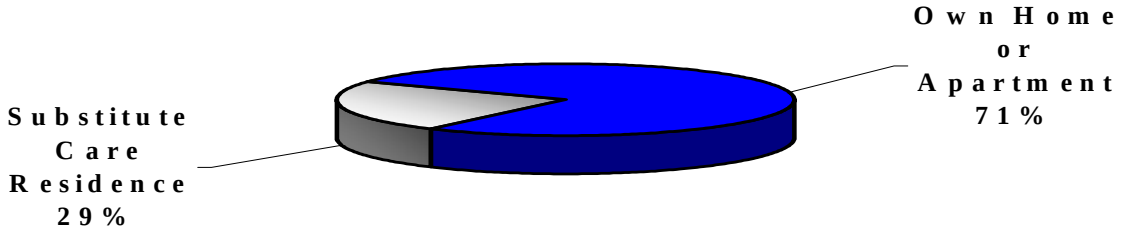
NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2004 HSRS.

TABLE 16 - COP and All Waiver Participants by Type of Residence

PARTICIPANTS BY TYPE OF RESIDENCE	Elderly	PD	DD	SMI	AODA Other	Total Participants	
Adoptive Home	0	1	86	1	0	88	<1%
Adult Family Home (AFH)	508	175	2,443	133	6	3,265	12%
Brain Injury Rehab Unit	1	14	7	0	0	22	<1%
Child Group Home	0	2	6	1	0	9	<1%
Community Based Residential Facility (CBRF)	1,601	269	1,463	285	25	3,643	14%
Foster Home	59	21	312	20	2	414	2%
ICF/MR: Not State Center	3	1	11	0	0	15	<1%
Nursing Home	10	1	1	0	0	12	<1%
Other Living Arrangement	1	0	0	0	0	1	<1%
Own Home or Apartment	6,921	3,699	7,863	610	46	19,139	71%
Residential Care Apartment Complex (RCAC)	168	10	0	1	0	179	1%
Residential Care Center (RCC)	3	0	3	0	0	6	<1%
Shelter Care Facility	2	2	4	2	0	10	<1%
State DD Center	0	0	3	0	0	3	<1%
Supervised Community Living	47	15	24	30	0	116	<1%
Unknown	0	0	0	1	0	1	<1%
TOTAL	9,324	4,210	12,226	1,084	79	26,923	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2004 HSRS.

FIGURE 3
Percentage of Participants Living in Own Home or Substitute Care Residence



FUNDING OF COMMUNITY LONG-TERM CARE BY TARGET GROUP

A total of $524,740,238 (federal waiver and state funds) was spent in 2004 on Community Options and all long-term care Medicaid Home and Community-Based Waivers. As a publicly-funded and managed program for community long-term care, COP-Regular contributes about 11 percent of the overall total. COP-Regular and COP-Waiver together contribute 28 percent of the overall total. [These figures do not include funds spent under the regular (non-waiver) Medicaid program.]

TABLE 17
COP and All Waivers
Funding of Community Long-Term Care by Target Group in 2004

Target Group	COP-Regular	COP-W	Subtotal COP-Regular, COP-W	CIP II	Subtotal COP-Regular, COP-W, CIP II	CIP 1, CLTS, BIW	GRAND TOTAL
Elderly	13,619,006 23%	65,841,254 73%	79,460,260 54%	23,406,889 44%	102,867,149 51%		102,867,149 20%
PD	6,360,063 11%	24,327,541 27%	30,687,604 21%	29,597,842 56%	60,285,446 30%	125,214 <1%	60,410,660 12%
DD	27,045,191 47%		27,045,191 18%		27,045,191 13%	322,341,829 100%	349,387,020 67%
SMI	10,973,441 19%		10,973,441 7%		10,973,441 5%	958,369 <1%	11,931,810 2%
AODA	137,387 <1%		137,387 <1%		137,387 <1%		137,387 <1%
Other	6,211 <1%		6,211 <1%		6,211 <1%		6,211 <1%
Total	$58,141,300 11%	$90,168,795 17%	$148,310,095 28%	$53,004,731 10%	$201,314,826 38%	$323,425,412 62%	$524,740,238 100%

Source: 2004 HSRS and Reconciliation Schedules.

- The elderly received 20% of the funds;
- Persons with physical disabilities (PD) received 12% of the funds;
- Persons with developmental disabilities (DD) received 67% of the funds;
- Persons with severe mental illness (SMI) received 2% of the funds; and
- Persons with alcohol and/or drug abuse (AODA) or other conditions received less than 1% of the funds.

FIGURE 4
Total COP and Waivers Spending by Target Group

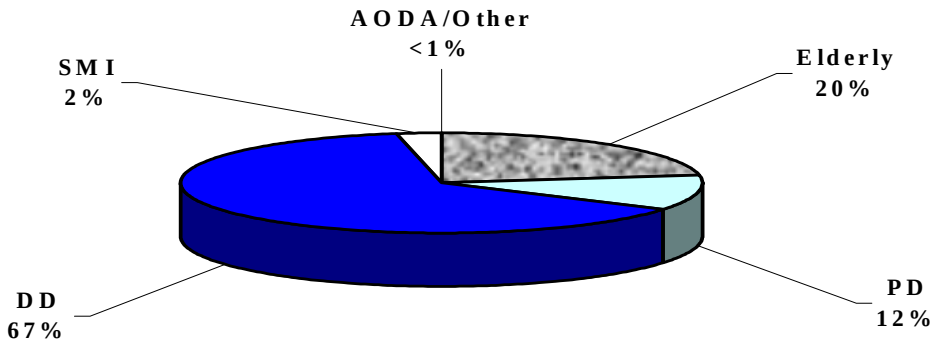
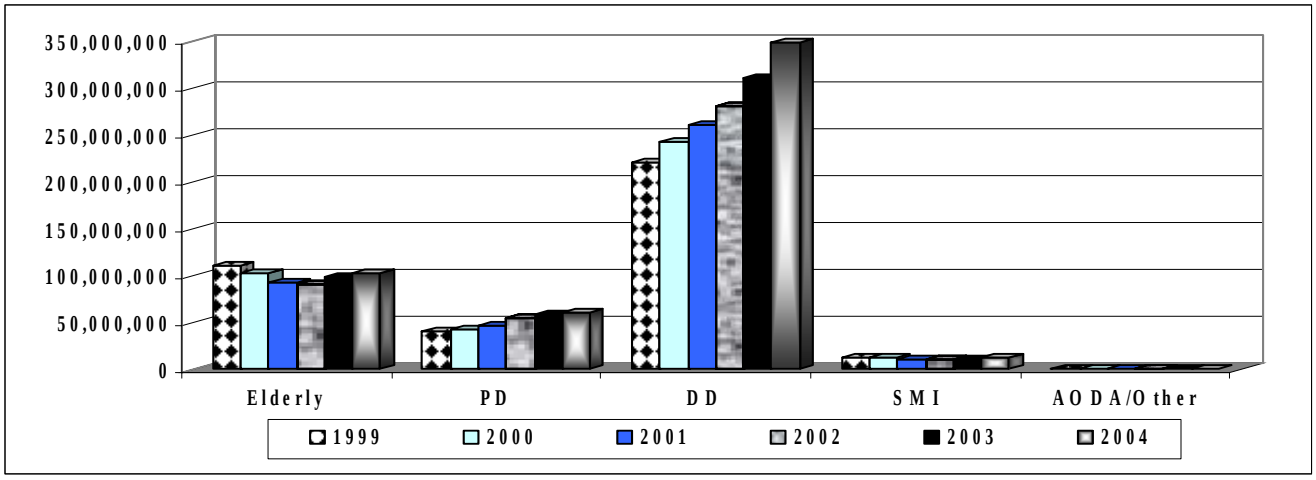


Figure 5 illustrates spending for participants by target groups. The "elderly" category includes all persons age 65 or older regardless of type of disability. All other participants are younger than 65. All participants have a need for a level of care equivalent to a nursing home care level.

FIGURE 5
Increase/Decrease in Funding for Community Long Term Care by Target Group 1998 – 2004



Note: In 2001 and 2002 COP and waiver participants converted to Family Care in five pilot counties.
Source: 2004 HSRS and Reconciliation Schedules.

HOW COP-REGULAR IS USED

Table 18 – Use of COP Regular

Target Group	COP Only	Supplemental COP (gap filling)	Additional GPR Match for Waivers	Admin, Special Projects, Risk Reserve	Assessments And Plans	Total Percent of COP-R Reported
Elderly	14.4%	57.3%	16.8%	14.5%	59.0%	23.4%
PD	7.1%	30.8%	7.0%	6.6%	20.7%	10.9%
DD	6.6%	11.9%	76.2%	12.9%	16.1%	46.5%
SMI	70.9%	0.0%	0.0%	65.8%	3.7%	18.9%
AODA/Other	1.0%	0.0%	0.0%	30.0%	0.1%	0.2%
TOTAL	21.2%	14.7%	55.2%	5.7%	3.2%	100.0%
Costs Reported*	$13,206,304	$9,165,515	$34,458,889	$3,565,024	$1,986,592	$62,382,324*

*Note: Reflects allowable costs reported on HSRS; however, actual reimbursement was $58,141,300.

- 21 percent of the total COP-Regular funds were used for services for COP only participants, 71 percent of whom are persons with a severe mental illness. There is no federal waiver available for the long-term care needs of this group.
- 15 percent of the total was used for current waiver participants to provide services that could not be paid for with waiver funds.
- 55 percent was used to create additional waiver slots and to cover the matching share of expenses for those participants whose cost of care exceeds waiver allowable rates.
- 6 percent was used for program and service coordination including one percent for special projects.
- 3 percent of COP-Regular funds were used to conduct assessments and develop care plans for COP or Medicaid waiver eligible people.

Of the funds used for additional match, $26.2 million was used for persons with developmental disabilities: $21 million was used as match to serve more people or for increased service costs, and $5.2 million was used to fund the match for CIP I so counties could earn additional federal funds when the average costs exceeded the allowable rate. When COP funding is used in this way it is referred to as "overmatch." For persons who are elderly or have physical disabilities, $7.4 million of COP-Regular funds were used as match to expand the COP-W program and $712,195 of COP-Regular funding was used as overmatch, i.e., used to fund the match for CIP II to earn additional federal dollars when average costs exceeded the allowable reimbursement rate.

PARTICIPANTS WITH ALZHEIMER'S DISEASE AND RELATED IRREVERSIBLE DEMENTIAS

In 2004, a total of 1,518 participants served in the COP, COP-W and CIP II programs were reported as having an Alzheimer's disease or related dementia diagnosis (e.g., Friedrich's Ataxia, Huntington's disease and Parkinson's disease). Of these 1,518 individuals, 7 qualified for the program by diagnosis alone. The total expenditures for participants with Alzheimer's or other irreversible dementia were $16,714,035.

MEDICAID NURSING HOME USE

The Community Options Program and the Medicaid Home and Community-Based Waivers have made possible a lower utilization of nursing home beds by Medicaid participants in Wisconsin. At the same time, COP also filled the gaps in unpaid care provided by family and friends. The extra support services paid for by COP reduce the burden on families who provide substantial amounts of unpaid care. The Community Options Program has enabled people with long-term care needs to continue to live in their own homes and communities. The Community Options Program has also been a stimulus to the growth of community care providers in the private sector. Since the beginning of COP and the development of alternatives to nursing home care, days of care paid for by Medicaid in nursing homes have declined. A portion of nursing home bed closures resulted in an additional 50 CIP II slots available in 2004.

CIP II AND COP-W SERVICES

Community Integration Program II and COP-Waiver participants utilize services federally authorized through its Medicaid waiver application and services traditionally available to all Medicaid recipients through the state's Medicaid Plan (e.g., card services). State Medicaid Plan services are provided to all Medicaid recipients eligible for a Medicaid card. The Medicaid Plan services are generally for acute medical care. Waiver services are generally non-medical in nature. Since both types of services are needed to maintain individuals in the community, expenditures for both types must be combined to determine the total public cost of serving waiver participants.

State statutes require use of Medicaid waiver funds only for expenses not covered in the Medicaid program. The waiver services provided, their utilization rate, and the total costs for each service are outlined in the table below. The total cost of Medicaid fee-for-service card costs for these waiver participants was $131,816,864.

TABLE 19
2004 Total Medicaid Costs for CIP II and COP-W Recipients

Total CIP II and COP-W Service Costs	$152,363,243
Total Medicaid Card Service Costs for CIP II and COP-W Recipients	$131,816,864
Total 2004 Medicaid Expenditures for CIP II and COP-W Recipients	$284,180,107

Source: 2004 Federal 372 Report.

Costs of care, services and environmental adaptations for waiver participants are always a combination of Medicaid State Plan benefits and waiver benefits. The coordination of benefits across the program is a key component of the Community Options Program and the waivers.

TABLE 20
2004 CIP II and COP-W Service Utilization and Costs

CIP II and COP-W Service Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Waiver Costs
Care Management	99.94	$18,958,818	12.44
Supportive Home Care/Personal Care	82.75	58,247,688	38.23
Adult Family Home	4.70	10,604,183	6.96
Residential Care Apartment Complex	2.26	3,843,446	2.26
Community Based Residential Facility	20.55	40,361,674	26.49
Respite Care	4.19	1,642,853	1.08
Adult Day Care	5.19	3,114,762	2.04
Day Services	1.70	1,440,718	0.95
Daily Living Skills Training	1.35	1,499,741	0.98
Counseling and Therapies	4.47	814,436	.53
Skilled Nursing	2.98	242,770	.16
Transportation	25.96	2,374,966	1.56
Personal Emergency Response System	40.88	1,459,159	.96
Adaptive Equipment	17.25	1,840,159	1.21
Communication Aids	1.83	68,925	.05
Housing Start-up	.09	3,183	.01
Vocational Futures Planning	.03	8,658	.001
Medical Supplies	24.03	1,269,538	.83
Home Modifications	3.46	1,306,578	.86
Home Delivered Meals	25.77	3,000,896	1.97
Financial management Services	4.01	260,092	.17
Total Medicaid Waiver Service Costs		$152,363,243	

Note: Totals may not equal 100% due to rounding. Source: 2004 Federal 372 Report.

TABLE 21
2004 CIP II and COP-W Medicaid Card Service Utilization

Medicaid State Plan Benefits Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Card Costs
Inpatient Hospital	3.8%	$5,916,919	4.5%
Physician (Physician Services, Clinic Services – including outpatient Mental Health)	74.4%	4,421,737	3.4%
Outpatient Hospital	51.9%	2,772,466	2.1%
Lab and X-ray	60.8%	893,402	0.7%
Prescription Drugs	94.6%	49,629,900	37.7%
Transportation (Ambulance and Non-Emergency Specialized Motor Vehicle)	49.7%	2,914,921	2.2%
Therapies (Physical Therapy, Speech and Hearing Therapy, Occupational Therapy, Restorative Care Therapy, Rehabilitative Therapy)	5.8%	316,541	0.2%
Dental Services	18.9%	562,367	0.4%
Nursing (Nurse Practitioner, Nursing Services)	0.2%	1,037,943	0.8%
Home Health, Supplies & Equipment (Home Health Therapy, Home Health Aide, Home Health Nursing, Enteral Nutrition, Disposable Supplies, Other Durable Medical Equipment, Hearing Aids)	68.5%	14,337,862	10.9%
Personal Care (Personal Care, Personal Care Supervisory Services)	33.0%	36,123,705	27.4%
All Other (Other Practitioners Services, Family Planning Services, HealthCheck/EPSDT, Rural Health Clinic Services, Home Health Private Duty Nursing – Vent, Other Care, Hospice, Community Support Program)	44.7%	12,889,101	9.7%
Total Medicaid State Plan Benefit Costs for Waiver Recipients		$131,816,864	

Notes: Totals may not equal 100% due to rounding. Source: 2004 Federal 372 Report.

PUBLIC FUNDING AND COST COMPARISON OF MEDICAID WAIVER AND MEDICAID NURSING HOME CARE

In addition to Medicaid-funded services, many waiver participants receive other public funds that can be used to help pay for long-term care costs. To provide an adequate comparison of the cost of serving persons through the Medicaid waiver versus the cost of meeting individuals' long-term support needs in nursing homes, an analysis of total public funding used by each group was completed.

Table 22 below indicates total public funds spent per capita on an average daily basis for nursing home and waiver care. It also indicates the breakdown between federal and state and/or county spending for each funding source.

TABLE 22

2004 Average Public Costs for CIP II & COP-W Participants vs. Nursing Home Residents

Average Cost per Person per Day

		Community Care Costs			Nursing Home Costs[1]			Difference		
Year	Cost Category	Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2004	Medicaid Program Per Diem	$45.44	$18.24	$27.20	$100.42	$40.30	$60.12			
	Medicaid Card	39.31	15.78	23.53	16.92	6.79	10.13			
	Medicaid Costs Subtotal[2]	$84.75	$34.01	$50.74	$117.34	$47.09	$70.25	$32.59	$13.08	$19.51
	COP – Services w/Admin.	2.40	2.40	0.00	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.17	0.17	0.00	n/a[3]	n/a[3]	n/a[3]			
	SSI	1.60	0.64	0.96	unk.	unk.	unk.			
	Community Aids	0.15	0.06	0.09	unk.	unk.	unk.			
	Total	$89.07	$37.28	$51.79	$117.34	$47.09	$70.25	$28.27	$9.81	$18.46

Source: 2004 HSRS and 2004 Federal 372 Report.

When all public costs are counted, expenses for CIP II and COP-W participants averaged $89.07 per person per day in 2004, compared to $117.34 per day for Medicaid recipients in nursing facilities. On average, then, the per capita daily cost of care in CIP II and COP-W during 2004 was $28.27 less than the cost of nursing home care.

TABLE 23

2004 Estimated Average Public Costs for CIP II & COP-W Participants vs. Nursing Home Residents

Adjusting for Level of Care Average Cost per Person per Day

		Community Care Costs			Nursing Home Costs*[1]			Difference		
Year	Cost Category	Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2004	Medicaid Program Per Diem	$45.44	$18.24	$27.20	$91.09	$36.55	$54,54			
	Medicaid Card	39.31	15.78	23.53	16.92	6.79	10.13			
	Medicaid Costs Subtotal[2]	$84.75	$34.01	$50.74	$108.01	$43.34	$64,67	$23.26	$9.33	$13.93
	COP – Services w/Admin.	2.40	2.40	0.00	n/a[2]	n/a[2]	n/a[2]			
	COP – Assessments & Plans	0.17	0.17	0.00	n/a[2]	n/a[2]	n/a[2]			
	SSI	1.60	0.64	0.96	n/a[2]	n/a[2]	n/a[2]			
	Community Aids	0.15	0.06	0.09	unk.	unk.	unk.			
	Total	$89.07	$37.28	$51.79	$108.01	$43.34	$64.67	$18.94	$6.06	$12.88

Source: 2004 HSRS and 2004 Federal 372 Report.

Assuming the same Medicaid card costs and other expenses, the average daily cost of nursing home care would have been $108.01 per person (Table 23, instead of $117.34 as reported in Table 23). The difference between average daily per capita waiver costs and average nursing home costs, therefore, would have been $18.94 instead of $28.27. This represents a difference of 18 percent, compared to 23 percent. Table 23 presents the estimated daily per capita public costs and the waiver/nursing home cost comparisons shown in Table 22 after adjusting the average nursing home per diem in this manner.

The following footnote references are for Table 22 and Table 23:

1. IMD costs are omitted from the total nursing home cost because persons who require institutionalization primarily due to a chronic mental illness are not eligible for CIP II or COP-W.
2. Medicaid reporting is subject to subsequent adjustments due to a 12-month claims processing period.
3. Nursing home residents are not eligible for the Community Options Program.

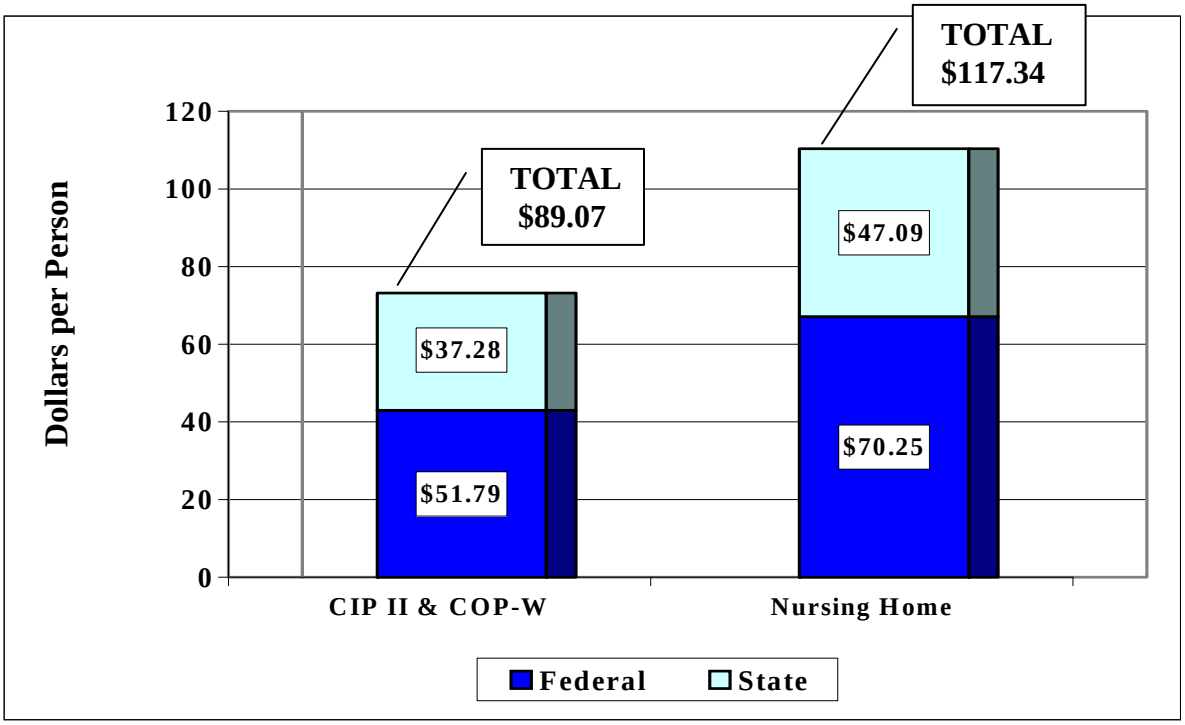
CARE LEVEL AND ITS SIGNIFICANCE FOR THE COST COMPARISONS

The cost differences evident in the previous comparisons, while calculated using actual costs of care for waiver participants and nursing home residents, may be influenced by differences in the care needs of these two populations. In 2004, 75 percent of CIP II and COP-W participants were rated at the intermediate care facility (ICF) level and 25 percent were rated at the skilled nursing facility (SNF) level. Corresponding figures for persons residing in nursing homes during 2004 were six percent ICF and 94 percent SNF, based on aggregate calendar year nursing home days of care. The significance of any care level difference that exists can be determined by re-estimating average daily and total public costs after adjusting the reported care level proportions.

Based on data supplied for the Department's annual cost report to the Centers for Medicare and Medicaid Services (CMS), the actual 2004 nursing home Medicaid per diem for ICF residents was approximately $82.88. For SNF residents the Medicaid per diem was approximately $113.38. If the proportions of nursing home residents receiving care at the ICF and SNF levels had been equal to the proportions reported for CIP II and COP-W participants (75 percent ICF and 25 percent SNF), estimated costs to Medicaid for nursing home care would have been $739,060,810 instead of $814,788,448. Given that there were 8,113,523 Medicaid-funded days of nursing care at the ICF and SNF levels combined in 2004, this level of total Medicaid spending would have translated to an average per diem across care levels of $91.09 (Table 23), instead of the previously calculated $100.42 (Table 22).

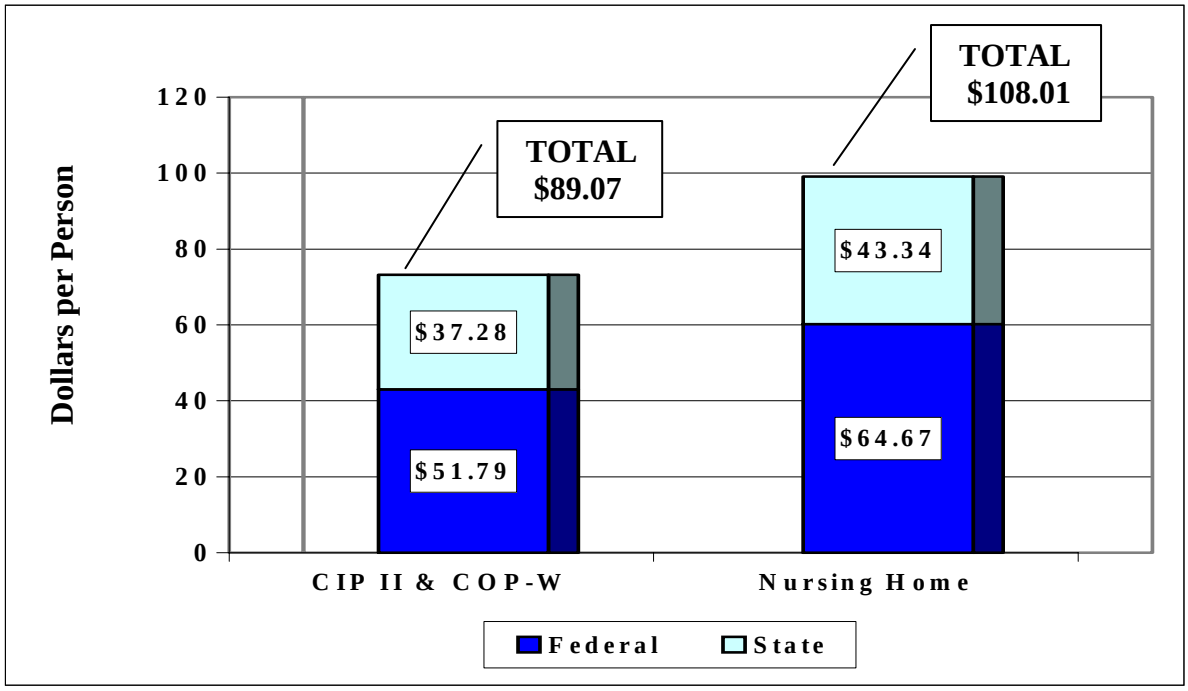
Using these adjusted figures, the potential impact of waiver utilization on total public spending can be estimated as it was in the previous section. That is, if the 12,594 waiver participants had spent the same 3,353,399 days residing in nursing homes, they would have incurred total public costs of $362,200,626 ($108.01 per day for 3,353,399 days), compared with the $284,180,107 they incurred while residing in the community. **Assuming equivalent care level proportions**, then, total public spending for CIP II and COP-W participants during 2004 was $78,020,519 less than the predicted cost of nursing home care for a comparable group. This figure is eight percent less than the $393,487,839 estimated using actual 2004 data, but it still represents a difference in total public costs of 27 percent compared with the cost of an equivalent volume of nursing home care. This revised estimate may represent the lower boundary of the difference in costs attributable to these waivers, while the estimate based on actual costs represents an upper boundary.

FIGURE 6
CIP II & COP-W vs. Nursing Home Care in 2004
Average Public Costs per Day



Source: 2004 Federal 372 Report.

FIGURE 7
CIP II & COP-W vs. Nursing Home Care in 2004
Adjusting for Level of Care
Estimated Average Public Costs per Day



Source: 2004 Federal 372 Report.

Appendix A

PERFORMANCE STANDARDS

A state leadership committee established the framework for assessing quality in the Community Options Program (COP). In order to ensure the goals of COP are met, person-centered performance outcomes valued by COP participants are incorporated into the acronym RESPECT:

Relationships between participants, care managers and providers are based on caring, respect, continuity over time, and a sense of partnership.

Empowerment of individuals to make choices, the foundation of ethical home and community-based long-term support services, is supported.

Services that are easy to access and delivered promptly, tailored to meet unique individual circumstances and needs are provided.

Physical and mental health services are delivered in a manner that helps people achieve their optimal level of health and functioning.

Enhancement and maintenance of each participant's sense of self-worth, and community recognition of his or her value is fostered.

Community and family participation is respected and participants are supported to maintain and develop friendships and share in their families and communities.

Tools for self-determination are provided to help participants achieve maximum self-sufficiency and independence.

RESPECT performance standards are measured by the extent to which:

- care managers identify a participant's health status and care needs, create or arrange for appropriate services to support and not supplant the help available from family, friends and the community, and monitor the performance of service providers;
- services respond to individual needs;
- participant preferences and choices are honored, and the participant is satisfied with the services delivered; and most importantly,
- participants are able to maintain a home of their own choice and participate in community life.

Appendix B

DEFINITIONS OF COMMUNITY LONG-TERM CARE PROGRAMS

COMMUNITY OPTIONS PROGRAM (COP):
The Community Options Program, administered by the Department of Health and Family Services, is managed by local county agencies to deliver community-based services to Wisconsin citizens in need of long-term assistance. Any person, regardless of age, with nursing home level of care is eligible for COP. The program began as a demonstration in eight counties in 1982 and was expanded statewide in 1986.

Funding: GPR/State = 100%

COMMUNITY OPTIONS PROGRAM-WAIVER (COP-WAIVER OR COP-W):
A Medicaid-funded waiver program which provides community services to the elderly and persons with physical disabilities who have long-term needs and who would otherwise be eligible for Medicaid reimbursement in a nursing home.

Funding: GPR/State = Approximately 40% (budgeted separately with COP GPR/state funds)
Federal = Approximately 60%

COMMUNITY INTEGRATION PROGRAM II (CIP II):
A Medicaid-funded waiver program that provides community services to the elderly and persons with physical disabilities *after a nursing home bed is closed.*

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IA (CIP IA):
A Medicaid-funded waiver program that provides community services to persons with developmental disabilities who are relocated from the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IB REGULAR (CIP IB):
A Medicaid-funded waiver program which provides community services to persons with developmental disabilities who are relocated or diverted from nursing homes and Intermediate Care Facilities – Mental Retardation (ICFs-MR) other than the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IB (CIP IB)/LOCAL MATCH:
A Medicaid-funded waiver program which provides community services to persons with developmental disabilities who are relocated or diverted from nursing homes and ICFs-MR other than the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (Community Aids, county match, or COP funds)
Federal = Approximately 60% (federal Medicaid funding)

CHILDREN'S LONG TERM SUPPORT WAIVERS (CLTS-WAIVER):
A Medicaid-funded waiver program that serves children and persons under the age of 22 who have a developmental disability, physical disability and those who have a severe emotional disturbance. CLTS waivers provide funds that enable individuals to be supported in the community.

Funding: GPR/State = Approximately 40% (state Medicaid, Community Aids, county match, or COP funds)
Federal = Approximately 60% (federal Medicaid funding)

BRAIN INJURY WAIVER:
A Medicaid-funded waiver that serves a limited number of people with brain injuries who need significant supports in the community. The person must be receiving or is eligible to receive post-acute rehabilitation services in a nursing home or hospital certified by Wisconsin Medicaid as a special unit for brain injury rehabilitation. This program began January 1, 1995.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

Appendix C

QUALITY ASSURANCE AND IMPROVEMENT OUTCOMES

Wisconsin has implemented a plan to demonstrate and document quality assurance efforts, which will ensure the health, safety and welfare of community waiver program participants. The quality assurance and improvement program combines a number of activities to assess and monitor program integrity, customer safety, customer satisfaction and program quality. The information obtained is provided as feedback to local and state agencies to promote quality improvement.

PROGRAM INTEGRITY

On-site monitoring reviews were conducted for a random selection of 500 cases in 2004. The reviews went well beyond the traditional federal requirements, which only identify payment errors, in an effort to gain in-depth information on program operation and policy interpretation. Where errors were identified, corrective action plans were implemented. For all criteria monitored, 93 percent compliance with the waiver requirements was verified. A summary of the monitoring categories and findings are as follows:

Category: FINANCIAL ELIGIBILITY

Monitoring Components:
- ✓ *Medicaid financial eligibility as approved in state plan*
- ✓ *Cost share*
- ✓ *Spend down*

Findings: 98 *percent of the factors monitored indicated no deficiency. Errors were detected in more complex areas of calculation, such as cost share and spend down. These areas have been emphasized in training and technical assistance activities. A disallowance occurred if the cost share was included in the expenses billed to the waiver.*

Category: NON-FINANCIAL ELIGIBILITY

Monitoring Components:
- ✓ *Health form*
- ✓ *Functional screen*

Findings: 98 *percent overall compliance with eligibility was measured. No instances of incorrect eligibility determination were identified under this category, although some cases failed to contain sufficient documentation.*

Category: SERVICE PLAN

Monitoring Components:
- ✓ *Individual Service Plan (ISP) developed and reviewed with participant*
- ✓ *Services waiver allowable*
- ✓ *Services appropriately billed*

Findings: 88 *percent of factors were in compliance. In a small percentage of the cases, incorrectly identified services or the omission of identified services within the ISP was noted. Only the inclusion of non-allowable costs resulted in negative findings and a disallowance of state/federal funding.*

Category: SERVICE STANDARDS AND REQUIREMENTS

Monitoring Components:
- ✓ *Waiver-billed services met necessary standards and identified needs*
- ✓ *Care providers appropriately trained and certified*

Findings: 87 *percent of factors were documented as error free. Documentation deficits accounted for many of the negative findings under this category. Disallowances were taken if standards had not been met.*

Category: BILLING

Monitoring Components:
- ✓ *Services accurately billed*
- ✓ *Only waiver allowable providers billed*
- ✓ *Residence in waiver allowable settings during billing period*

Findings: 91 *percent compliance was found in these categories. Disallowances were taken.*

Category: SUBSTITUTE CARE

Monitoring Components:
- ✓ *Contracting requirements have been met*
- ✓ *Only waiver allowable costs calculated and billed*

Findings: 96 *percent overall compliance was found. Documentation or errors due to room and board versus care and supervision were evidenced in a few cases. Residential care has proven to be a challenging area for services providers and is being addressed with technical assistance and training. Disallowances were taken.*

CORRECTIVE ACTION

In addition to a wrap-up meeting following a monitoring visit, a written report of each monitoring review was provided to the director of the local agency responsible for implementation of the waiver. The report provides the agency with a list of health or safety issues, indicating where action is needed at the local level. The reports also cited errors or deficiencies and required that the deficiency be corrected within a specified period of time, between one and 60 days. Follow-up visits were conducted to ensure compliance when written documentation was insufficient to provide assurance. Results from the consumer outcomes and satisfaction surveys are also written in the report to present an overview of the county system and identify trends in service areas.

Where a deficiency correlated with ineligibility, agencies were instructed to correct their reimbursement requests. In addition, agencies were required to develop a plan to modify their practices. In 2004, a total of 38 agencies were monitored. In 22 instances, disallowances were taken from counties where retroactive corrections could not be implemented. The total disallowance for the 22 agencies combined was $104,064. Disallowances were taken in areas including billing of non-allowable services, data entry errors, lack of documentation for billed services, billing during a period of ineligibility for waiver services, and inaccurate collection of cost share.

PROGRAM QUALITY

During 2004, 500 randomly selected participants responded to 22 questions during in-person interviews regarding satisfaction with waiver services. Both direct responses and reviewer assessments of those responses were recorded.

The factors studied regarding care management services were:

- ❑ Responsiveness to consumer preferences
- ❑ Quality of communication
- ❑ Level of understanding of consumer's situation
- ❑ Professional effectiveness
- ❑ Knowledge of resources
- ❑ Timeliness of response

The factors studied for in-home care were:

- ❑ Timeliness
- ❑ Dependability
- ❑ Responsiveness to consumer preferences

The factors studied for persons living in substitute care settings were:

- ❑ Responsiveness to consumer preferences
- ❑ Choices for daily activities
- ❑ Ability to talk with staff about concerns
- ❑ Comfort

Table 24 combines and summarizes the findings of the survey. Satisfaction in substitute (residential) care settings is somewhat lower than satisfaction with services in one's own home.

Table 24
Program Quality Results

SATISFACTION CATEGORY	PERCENTAGE OF POSITIVE RESPONSES
Care manager is effective in securing services	94%
Good communication with care manager	96%
Care manager is responsive	96%
Active participation in care plan	90%
Satisfaction with in-home workers	93%
Substitute care services are acceptable	85%
Satisfaction with substitute care living arrangement	85%

Source: 2004 Quality Monitoring Reviews.

CONTINUOUS QUALITY IMPROVEMENT PROJECTS

The information collected from various quality assurance efforts was incorporated into a variety of ongoing quality improvement projects. Examples of those activities are listed below:

- Provide issue specific or county specific intensive monitoring or training where significant errors have been identified. Repeat monitoring where necessary.
- Develop issue specific technical assistance documents. This includes answers to the most frequently asked questions. The document entitled "WaiverWise" is now available on the Department of Health and Family Services website.
- Conduct statewide training in the areas of Fiscal Management, Eligibility, Service Standards, Advanced Care Manager/Economic Support Training, and Outcome-Based Care Planning.
- Utilize enhanced data collection and reporting formats to identify target areas for monitoring and technical assistance.
- Produce and distribute case specific fiscal reports containing potentially correctable reporting errors.
- Provide Long Term Care Functional Screen trainings for certified screeners.
- Update Medicaid Waiver Manual and develop an orientation to the manual for care managers.
- Continue to transition responsibility to county agencies for quality assurance of the annual recertification of participant eligibility.

We gratefully acknowledge the efforts of County Community Options Program Lead Agencies to report COP and waiver activities and expenditures completely and accurately, since this information is the foundation for the data compiled in this report. Questions may be directed to:

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